## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 11/21/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CDRRECTION		(Xt) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	LE CONSTRUCTION 01 - Main Building 01	(X3) DATE SURVEY COMPLETED		
		495362		B. WING	·	R 11/17/2016		
NAME DF PROVIDER DR SUPPLIER STREET ADDRE					TE, ZIP CODE			
ASHLAND	ASHLAND NURSING AND REHABILITATION 906 THOMPSON STREET ASHLAND, VA 23005							
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES				ID ID	PRDVIDER'S PLAN OF CORRECTI	DN (X5)		
PREFIX TAG		ICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX (EACH CDRRECTIVE ACTION SHOULD BE OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)						
{K 000}	INITIAL COMMENTS			{K 000}				
	with NFPA-13  An unannounced Recurvey was conducted with 42 Code of Fede Requirements for Lonfacility was surveyed LSC 2000 Existing recurrence.	ype II(000) r sprinklered in accordance tification Life Safety of 10/20/16 in accordance Regulation, Part 48 or Care Facilities, for compliance using the gulations. The facility on the Requirements for	Code ce 3: The ne	·				
{K 025} SS=E	Smoke barriers shall I least a one half hour to constructed in accord barriers shall be permatrium wall. Windows fire-rated glazing or b steel frames.  8.3, 19.3.7.3, 19.3.7.5. This Standard is not Based upon observatibarrier walls have per	Title 42 Code of  Safety from Fire.)  ETY CODE STANDARE  be constructed to provi- fire resistance rating an ance with 8.3. Smoke nitted to terminate at an shall be protected by y wired glass panels ar  met as evidenced by: ions the fire rated smoke netrations, joints and fire stopped and could ne side of the smoke	de at nd nd	{K 025}				

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable t4 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

fX6) OATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PRDVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED R	
		495362		B. WING		11/17/2016	
NAME OF PROVIDER OR SUPPLIER  AS HLAND NURSING AND REHABILITATION  STREET ADDRESS, CITY, STATE, ZIP CODE  906 THOMPSON STREET  ASHLAND, VA 23005							
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES IT BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
{K 025}	Between 3:00 PM and observed that there as ceilings in the fire rate have not been fire stored and product in Wing 2 corridor doors near root.	d 7:20 PM on 10/20/16 tre penetrations above to smoke barrier walls opped with a listed design 2 Back Hall above the com 220, and by Wing scross corridor doors ne	the that gn cross	{K 025}			

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STATEMENT OF OEFICIENCIES AND PLAN OF CORRECTION		(Xt) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01		(X3) OATE SURVEY COMPLETEO		
		495362		B. WING		R 11/17/2016		
NAME OF PROVIDER OR SUPPLIER STREET ADD				DRESS, CITY, STATE, ZIP CODE				
ASHLAND NURSING AND REHABILITATION 906 THOMPSON STREET ASHLAND, VA 23005								
IX4] IO PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF OEFICIENCIES IT BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		IO PROVIDER'S PLAN OF CORRECTION ORY PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCEO TO THE APPROPRIATE OEFICIENCY)				
{K 000}	INITIAL COMMENTS	6		(K 000)				
(K 025} SS=E	with NFPA-13  An unannounced Recsurvey was conducted with 42 Code of Feder Requirements for Lor facility was surveyed LSC 2000 Existing recont in compliance with Participation Medicar  The findings that follonon-compliance with Regulations, 483.70(a) et seq (Life NFPA 101 LIFE SAFE Smoke barriers shall least a one half hour constructed in accord barriers shall be permatrium wall. Windows fire-rated glazing or bisteel frames.  8.3, 19.3.7.3, 19.3.7.5. This Standard is not Based upon observat barrier walls have permatrier wall have permatrier wall have permatrier wall have permatrier walle	ype II(000) y sprinklered in accordance tification Life Safety d 10/20/16 in accordance and Regulation, Part 48 ag Term Care Facilities, for compliance using the gulations. The facility on the Requirements for e and Medicaid.  In wide Medicaid.  In Safety from Fire.)  ETY CODE STANDARD  The resistance rating are ance with 8.3. Smoke nitted to terminate at an shall be protected by y wired glass panels are met as evidenced by: ions the fire rated smoletrations, joints and fire stopped and could ne side of the smoke	Code ce 3: The ne was	(K 025)	KO25 Step 1.  -All penetrations, joint, a openings have been sealed thus preventing the passa smoke from one side of the smoke barrier to the other engaging Mountain Communication Systems remove deficient product around penetrations and of-wall joints, and instal tested and listed UL System and/or Engineering Judgements for all penetrations and fire rate joints to meet ANSI E81 standards, applicable but and NFPA codes. We witten documentation of work performed, as well tag and label all penetral and joints	ed lige of line lige of line lige of line lighter ligh		

Any deficiency stetement ending with en esterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made evailable to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	(X.I) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
	495362	B. WING		R 1 <b>1/17/201</b> 6	
NAME OF PROVIDER OR SUPPLIER	STREET ADO	RESS, CITY, STA	ATE, ZIP COOE	<u> </u>	
ASHLAND NURSING AND REHABILITATION	·	OMPSON ST ND, VA 230			
PREFIX (EACH DEFICIENCY MUST BE PRECEDED B	SUMMARY STATEMENT OF DEFICIENCIES  ACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE OFFICIENCY)			O BE COMPLETION	
Findings include:  Between 3:00 PM and 7:20 PM on 1 observed that there are penetrations cellings in the fire rated smoke barrie have not been fire stopped with a list and product in Wing 2 Back Hall abocorridor doors near room 220, and b Front Hall above the cross corridor droom 314.	s above the er walls that ted design ove the cross y Wing 3	{K 025}	Step 2.  -Ashland Nursing and Rehabilitation will begin to methodically inspect fire in wall, starting from one end the building to the other, identifying deficient fire stopping, or lack of fire stopping, and immediately when identified, or create acceptable interim life saft measure.  Step 3.  -Ashland Nursing and Rewill begin to implement a comprehensive Barrier Management Program the consists of firestop trainicabove celing penetration permits and proof of instemanufacture training.  Step 4.  -Compliance will be monitored via the Quality Assurance Performance Improvement (QAPI) pro-	ated d of  fix an ety  hab at ng, caller	

- -Audits will be developed to identify correcting existing, newly discovered deficiencies, compliance with Barrier Management Program and will be conducted monthly X 3 months to verify compliance.
- -Results will be reported at the monthly QAPI Meeting as appropriate.

Step 5.

-Date of completion: 12-31-16